Retiree Drug Subsidy (RDS) Center Authorized Representative Verification

Please type or print plainly.

1. NAME OF AUTHORIZED REPRESENTATIVE

2. PLAN SPONSOR NAME

3. **PLAN SPONSOR IDENTIFICATION NUMBER (NOT the EIN)**

4. VERIFIER'S NAME (may NOT be the Authorized Representative)	**5. VERIFIER'S JOB TITLE**
6. VERIFIER'S EMAIL ADDRESS	**7. VERIFIER'S TELEPHONE NUMBER** (include area code)

8. VERIFIER'S BUSINESS ADDRESS

(Street Address)

(City)

(State)

(Zip Code)

9. VERIFIER'S SIGNATURE	**10. DATE**

This document is a confirmation for purposes of the Centers for Medicare & Medicaid Services' (CMS) Retiree Drug Subsidy (RDS) program, the individual named in (1) above is acting as the Authorized Representative (An individual to whom the Plan Sponsor has granted the legal authority to bind the Sponsor to the terms of the Plan Sponsor Agreement in the RDS application. Examples of the Authorized Representative include the Sponsor's general partner, CFO, CEO, president, Human Resources Director, or an individual who holds a position of similar status and authority within the Sponsor's organization. For multi-employer plans, the Authorized Representative does not have to be an employee of the Sponsor, but may be a member of the jointly appointed board of trustees, which includes both labor and management trustees).

Please return this completed form to CMS via FAX at 410-786-6301, email at RDSpayment@cms.hhs.gov, or United States mail to 7500 Security Boulevard, Mail Stop C1-22-06, Baltimore, MD 21244-1850.